UNITED STATES DEPARTMENT OF AGRICULTURE
Extension Service, Division of Agricultural Economics
Washington 25, D. C.

# E X T E N S I O N  H E A L T H  E D U C A T I O N

Summary of a Round Table Conference
at Kansas City, Missouri, February 5-9, 1950



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# EXTENSION HEALTH EDUCATION

## CONTENTS

# FOREWORD



Health education has always been a part of extension work. In addition to furthering improvement in nutrition, county agricultural and home agents have long developed other programs to improve the health of farm men, women, and children. What is new about extension health education at present is that its importance is now fully recognized and it has become part of extension policy to develop a broadened, well-rounded health education program.

Health education as part of the extension program was given full recognition in 1946 when the Federal Extension Service employed a specialist in rural health education to assist States in developing this phase of extension work to a greater degree. Since that time more than a dozen States have employed full-time or part-time specialists in rural health education. In addition, two States--Kansas and Illinois--had had such a worker since the First World War. Several States are looking for trained personnel and several others have formed extension health committees to explore the problem and determine how Extension can best develop the field of health education.

The new extension health specialists find it very helpful to be able to get together to share their experiences and develop a common philosophy and objectives. The fifth national conference on rural health services, sponsored by the Rural Health Committee of the American Medical Association in Kansas City, afforded an excellent opportunity for the extension health educators who attended that meeting to get together. They spent 5 days after the A.M.A. conference discussing the extension health program as it has developed in their own States and as they see its possibilities for the future. The report of that meeting gives a good picture of the scope and major focus of their work. I therefore commend this report not only to the States now employing health specialists but especially to those which contemplate doing so. It is a valuable guide to the development of a well-rounded health education program that is an integral part of the total extension program.

Special credit is due to Helen L. Johnston, now health economist in the United States Public Health Service, for invaluable assistance in preparing the manuscript of this report based on her notes and on the preliminary work on the manuscript completed by Elin L. Anderson before her absence due to illness. Extension health work will long reflect the ideals and leadership of Miss Anderson, now deceased, who was on the Extension staff of the United States Department of Agriculture for a number of years and who gave so much of her life for the cause of better health and welfare in rural America.

M. L. Wilson

Director of Extension Work

# SUMMARY - THE HEALTH EDUCATOR IN A STATE EXTENSION SERVICE

By Elin L. Anderson

The health educator in the extension service of a State college of agriculture seeks to do the following:

1. To direct the various health activities of the extension service into a unified health education program focused primarily on individual, family, and community health planning.

2. To bring to bear on such health planning all the resources of the extension service and the State university that make for improvement in the physical, mental, and social well-being of people.

3. To relate these resources of the college to those of all health and other organizations and agencies concerned with raising health standards.

The health educator serves the members of the extension service staff and rural leaders in developing effective personal, family, and community health plans and programs. His or her services have four major phases:

1. To develop among rural people an appreciation of and a sense of responsibility for the establishment of health habits, practices, services, facilities, and laws that will achieve optimal levels of physical, mental, and social well-being for the individual and for his community.

2. To assist rural people with the process by which the interest, initiative, support, and participation of all the people in the entire community may be enlisted:

   a. To gather and study the facts relative to the health and medical needs of each family in relation to the total community.

   b. To develop plans and programs to meet these health and medical needs.

   c. To mobilize all the resources within individuals and their environment, local, State, regional, and national, needed to carry out programs for family and community health improvement.

3. To interpret the services of health organizations and agencies to rural people and the needs of rural people to health organizations and agencies, so that general health programs may be effectively adapted to meet rural needs and special health programs developed to meet special rural conditions.

4. To assist rural people to understand the interdependence of local, State, national, and international health problems; on the basis of this knowledge to assist them in developing public health policy, local, State, national, and international, that will bring more and more opportunity for all people to obtain the goal of "complete physical, mental, and social well-being, not merely the absence of disease or infirmity."

ROUND TABLE ON EXTENSION HEALTH EDUCATION
Kansas City, Mo.
February 5-9, 1950

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The annual Rural Health Conference sponsored by the American Medical Association has become a meeting ground for a number of farm and professional groups concerned with rural health improvement. During the 2-day meeting in Kansas City, February 3 and 4, 1950, special attention was given to the role of the Extension Service in health education. Most of the extension specialists in health education attended. A few met with the doctors for a day before the regular conference.

The period immediately after the conference provided an excellent opportunity to meet the requests of the extension health workers to have a special meeting of their own for discussion of their common problems. Since health specialists are new in extension, the pooling of experience and the developing of a common point of view and approach to their work is particularly important. A meeting for extension health workers, therefore, was planned for February 5 to 9.

## CONFERENCE METHODS AND ACCOMPLISHMENTS

### What planning was done

Through correspondence and conversations the major problems for consideration at the meeting were defined. Tentative agenda were drawn up. These agenda, however, served only as a general guide. They were adapted at the meeting as the group's concept of its needs and interests grew.

### How the group worked

The entire meeting was in the form of a round-table discussion. Except for consultants on Sunday there were no speakers and no speeches. One or two resource people were available, but the major resources lay within the group itself. A blackboard and educational materials brought by the health specialists were in constant use. When a difficult problem arose the group sometimes broke up into two or three smaller groups to consider it from different points of view. Then all members would come together to merge these points of view into one statement agreed upon by all. Only once did the group break up into two committees to consider two different topics. This, however, proved much less satisfactory and beneficial to the total group than when all members worked on the same common problem.

### What was accomplished

At the end of 4 days, it was evident that several important topics were untouched; several dealt with needed further study; and some had been restated in the light of broader experience. But that is the usual outcome of any conference. What was unusual about this meeting was that it marked

a turning point in the workd of extension health educators. It meant a reorientation for all with respect to: (1) The major focus of extension health education; (2) the place and the development of a health education program within the total extension program; and (3) the major extension methods for health education.

What perhaps was even more unusual about this meeting was the spirit of the extension health educators. They have a deep faith in the value of their work. They are all pioneering in a new field. Sometimes they are even strangers to the long-established extension pattern of work. They have no familiar landmarks to guide them. These may be some of the reasons why the extension health workers have developed a special quality of supporting each other in both work and play and of bringing out in each other the best abilities and sometimes unknown talents. If this enthusiasm, comradeship, and cooperative effort--characteristic of all pioneer work--continues as the guiding spirit of extension health education, much will be accomplished to bring better health to rural people.

"Whodunit"

Twenty-two people representing 16 States and the District of Columbia attended the meeting. Three stayed for Sunday only. At the time of this meeting, 12 States employed a full-time extension health specialist. All these except South Carolina were represented at the meeting. In addition, extension workers assigned to develop the health education program in three other States attended. One State was represented by an administrator. Vacancies in the position of extension health educator in Florida and Illinois prevented representation from these States. Two representatives from the United States Department of Agriculture and one from the United States Public Health Service attended to help with the conference.

The group was composed of the following:

Elin L. Anderson, Washington, D. C., extension specialist, rural health education, Extension Service.
Edith Bangham, Wisconsin (Sunday only), extension professor and assistant State leader, college of agriculture.
Helen Becker, Nebraska, extension health education specialist.
Annette S. Boutwell, Mississippi, extension health education specialist.
Martha Brill, Kansas, extension specialist in home health and sanitation.
Douglas Ensminger, Washington, D. C., in charge, Educational Research Section, Extension Service.
Astrid C. Erickson, North Dakota, extension agent in health planning.
Lucille Higginbotham, Georgia, extension health specialist.
Helen Johnston, Washington, D. C., Division of Medical and Hospital Resources, U. S. Public Health Service.
Amy Kelly, Missouri, State extension agent, college of agriculture.
Raymond Lenart, Ohio, health education consultant.
Frances H. Macdonald, Montana, extension rural health specialist.
Mabel Mack, Oregon, State extension service.
Malcolm Mason, Indiana, extension rural health specialist.
Paul Miller, Michigan, extension specialist in sociology and anthropology.

Claribel Nye, California, State home demonstration leader.
Rosa M. Ordonez, Puerto Rico, extension health and hygiene specialist.
Hallene Price, Missouri (Sunday only), county home demonstration agent.
Louis S. Reed, Washington, D. C. (Sunday only), Division of Medical and Hospital Resources, U. S. Public Health Service.
Helen M. Robinson, Arkansas, extension health education specialist.
Evangeline J. Smith, Wyoming, extension nutrition specialist.
David Steinicke, Michigan, extension specialist in health and safety organization.

## THE ROUND-TABLE DISCUSSION

Sunday, February 5, was devoted mainly to the discussion of progress in the hospital construction program. Some consideration was also given to the new educational program on cardiovascular diseases. The summary for that day has been prepared as part of the appendix to this report of the round-table discussion on over-all Extension health education.

On Monday, February 6, the round-table discussion began with a consideration of the major problems facing extension health workers. The specialists stated that what they most wanted out of the conference was clarification of the following:

1. Extension's place in the development of a rural health program.
2. The role and function of the extension health specialist.
3. The "what" and "how" of the development of a unified extension health program in which all the resources of the extension staff are pooled.
4. Methods of stimulating community awareness of health needs and community participation in the development of plans and programs to meet these needs.
5. How to deal with special health programs such as prepayment plans, the hospital construction program, the health programs of 4-H and home demonstration, and others.

It was agreed that item 5, especially the 4-H health program, was of such importance that it needed to be dealt with in a special conference called for that purpose. The other four topics were all considered. The summary of the 4-day discussion follows.

### Extension's place in a rural health program

What is a rural health program? What is Extension's responsibility in such a program? These were questions put by a newcomer to the group. Since these questions are still frequently raised by extension workers, the health educators thought it well to clarify their concepts.

The springboard of a rural health program, they said, is the definition of health made by the World Health Organization, namely that "Health is a state of complete physical, mental, and social well-being, not merely the absence of disease or infirmity." The scope of a health program based on this definition has scarcely been envisioned. To lay the foundation of it in rural areas requires the cooperative effort of all organizations and agencies serving rural people. While perhaps not the most important, certainly not the least important among these organizations and agencies is the Extension Service.

All recognized that health education in Extension is not new. Extension has always conducted health education programs in nutrition and rural sanitation, for example. It has conducted educational programs for special groups such as 4-H and home demonstration. In addition, virtually all of the programs concerned with the improvement of the economic well-being of rural people are in some respect health measures. Many county agricultural and home demonstration agents have cooperated with health organizations in the development of local health programs as a part of their responsibility to local rural people.

But in the light of new concepts of health, this is not enough. The group agreed that the development of health programs leading to the greater availability of health and medical services is basic to improving the economic and social, as well as the physical and mental well-being of the people. Helping to develop such programs so that the benefits of modern medical science to promote health, prolong life, and cure and prevent disease can be fully shared by rural people is the central function of extension specialists in health education.

That is what is new in extension health education. This addition to the total extension program will not only strengthen the total effort of all organizations and agencies primarily concerned with health improvement, but it will enhance the health aspect of all regular extension work.

As Douglas Ensminger pointed out, formerly county agricultural and home demonstration agents developed health programs in cooperation with local health organizations and agencies if time from their regular duties permitted. Now it is a matter of administrative policy that each State extension service shall take a responsibility and definite part in health education. In other words, health education no longer comes about by chance in extension, but is an integral part of the over-all extension program.

The group emphasized that the health program in Extension does not mean that Extension should take primary responsibility for health work that is the function of health departments and other health organizations and agencies. They believed, however, that the objectives of a health program in rural areas can be most fully realized only through the cooperative effort of the major agencies serving rural people.

The chief contributions that the Extension Service can make to a rural health program are as follows:

1. It can serve as a middleman between health organizations and agencies and rural people, interpreting to health agencies the needs of rural people, and interpreting to rural people the programs of health agencies.
2. It can advise on the adaptation of general health programs to meet rural needs, and on the development of special programs to meet special rural needs.
3. Organized as it is, close to the people in local communities, it can offer its knowledge and experience with the psychology, economics, and social organization of rural people that will make for the most effective development of any health program.
4. Its long experience with adult teaching methods can be adapted to helping people understand and organize to meet and solve their health and medical problems.

"Health is everybody's business"

The article entitled "Health Is Everybody's Business," by Mayhew Derryberry, Ph.D., U. S. Public Health Service, describes the concern of all groups with health improvement and how best results are developed when all groups concerned pool their efforts toward common health goals, with no one agency claiming a special right in health work.

A member of the group cited an outstanding example of how several agencies cooperated to meet a health problem in California. In the San Joaquin Valley, two children of a migrant laborer died of malnutrition. This in the midst of abundance. The Governor was extremely disturbed. He called the agencies most concerned together--the health department, extension service, and social welfare department. The social welfare department established depots for the distribution of surplus foods at a number of points in the county convenient to families in need. The health department added four nutritionists to its staff. The extension service added two home demonstration agents experienced in working with low-income families. The workers from the health department and the extension service worked out successful uses of surplus products. As the program developed successfully, a representative of the health department commented: "Too often the agencies work along parallel lines, each knowing little of what the others do. The accomplishments in the San Joaquin Valley afforded a demonstration of how several agencies can cooperate in solving a specific problem. More of this type of cooperation is needed."

What Extension is now doing in health education

As a first step to considering the opportunities for extension workers in health education, it seemed important to the group to review what is now being done. On the basis of field trips and work reports of health specialists, Miss Anderson summarized on the blackboard the present health education program of Extension as developed in those States employing extension health specialists during the fiscal year 1948-49. The program was outlined according to major health topics. With each topic appeared a brief sketch of what was being done, the method used, and which States were developing programs under this general heading.

## Present Health Education Program in Extension

| WHAT | HOW | WHERE |
|---|---|---|
| 1. Child health services. Immunization, clinics, well-baby conferences, tuberculosis testing, home nursing, oral hygiene, children's diseases, diet, posture, safety, mental health. | 4-H and home demonstration club projects and activities. | Nebr., Kans., Ill., N. Dak., P.R., Wyo., Miss. |
| 2. Adult health practices. Control of cancer, tuberculosis, and undulant fever; care of feet; home nursing; mental health; safety. | 4-H and home demonstration club projects and activities. | Ark., Kans., P.R., N. Dak., Ind., Wyo. |
| 3. Rural Sanitation. Screening; fly, insect, and rat control; care of milk; installation of sanitary privies and sewage systems; safety. | Usually through 4-H and home demonstration clubs; occasionally through health committees or other planning groups. | Nebr., Ind., P.R., Mich. |
| 4. Health services and facilities. Information programs on hospital construction, fund raising, furnishing rooms, recruitment of health personnel, raising scholarship funds. | Health councils or subcommittees of agricultural planning; State and district conferences. | Ohio, Ind., N. Dak. |
| 5. Prepayment plans. Information programs on available insurance plans. | Home demonstration clubs and health committees. | Ark., Mont., Nebr. |
| 6. Public health services. Information programs on local health services; financing; how services may be obtained; school health services. | Mainly health councils and committees; home demonstration clubs; State and district conferences. | Ohio, Mont., N. Dak., Wyo., Ind. |
| 7. Community organization for health. Assisting in establishment of health councils or subcommittees of agricultural planning; developing local health surveys and handling discussion meetings; district and State conferences. | County agricultural planning committees; interested leaders or agencies. | Ohio, Ind., Mont., and a lesser degree in Nebr., Ark., S. C. |

Present program in relation to needs

Is the present extension program directed toward major health needs? This was the question raised after the review of present extension health work. In the discussion that followed the group agreed that gains have been made through present procedures. At the same time the existing program has weaknesses. Some organizations and agencies were ready at the very start to push for special health programs that lent themselves to mass education. Moreover, the nature of some organizations facilitated a mass education approach. As a result, the existing program in some cases has become a series of more or less unrelated health activities. It is not necessarily based on family and community health needs determined by thorough analysis of the problems facing rural people.

Present health needs of rural people

If the present health education program is not necessarily focused on the needs felt by rural people, what then are those needs? When this question was raised the health educators listed the six areas in which their experience indicated rural people were most anxious to receive help. They were as follows:

1. Public health policy: As the result of increased discussion of all types of health legislation--county referendums for local health units, State legislation for various health programs, and especially the literature disseminated on "socialized medicine"--an important interest of rural people according to the group's observation is to obtain unbiased information on all types of proposed health legislation--local, State, and national. This enables rural people to take their full responsibility for formulating public health policy affecting the health of their families and communities.

2. Health facilities and services: Another basic concern of rural people is to have available and make effective use of modern health and medical services and facilities. This involves concern about the following:

a. The establishment of hospitals and health centers.

b. Methods of obtaining and holding doctors, dentists, nurses and other health personnel in rural communities, including the responsibility of rural people for recruiting health personnel and for providing scholarships. The concern of rural people in this area also extends to the nature of training for rural service offered by professional schools.

c. Understanding of the benefits of local public health units and how these may be made available to all rural people.

d. Knowing and making effective use of the health services of the many available public and voluntary health agencies and organizations.

e. Broad, general knowledge and understanding of desirable standards for all health services and facilities.

3. Financing health services:

a. Costs and methods of financing local health units.

b. Costs of building and maintaining hospitals, health centers, clinics, and other health facilities.

c. Types of insurance plans for family health protection; their organization set-up, benefits, and costs.

4. Farm, home, and community sanitation and safety.

5. Information about and responsibility for developing habits, practices, services, facilities, and laws needed to build optimum health.

6. The community organization process by which families and communities mobilize their resources to study their health needs, make plans, and develop programs to improve their health habits, practices, services, facilities, and laws.

The job of the extension health educator

When the list of extension health activities was compared with the list of present needs of rural people, the health educators decided that their work needed to be redirected and reorganized.

What they had been doing had often been both necessary and valuable in getting the program started. As one health specialist put it, "You took whatever handle you could get. Usually that was some special program like brucellosis, cancer control, chest X-rays, or some other program that got wide public attention and lent itself easily to mass education." On the other hand, what is now needed is to put these health activities into a broader frame of reference so that:

1. All extension health activities are coordinated into one health program focused on family and community health planning;

2. The extension health education program becomes an integral part of the over-all extension program. Only in this way can all resources of the Extension Service for health improvement be brought to bear on raising family and community health standards.

Realization of this fact gave the health specialists pause. Yet they all agreed that the major focus of their work must be to assist the entire extension staff and rural leaders with family and community health planning. To do this effectively, they decided that their work had four major aspects:

1. To develop among rural people an appreciation of and a sense of responsibility for the establishment of health habits, practices, services, facilities, and laws that will achieve optimal levels of physical, mental, and social well-being for the individual and for his community.

2. To assist rural people with the community organization process by which the interest, initiative, support, and participation of all people in the community may be most fully enlisted:

a. To gather and study the facts relative to the health and medical needs of each family in relation to the entire community.

b. To develop plans and programs to meet these health and medical needs.

c. To mobilize all the resources within individuals and their environment--local, State, regional, and national--needed to carry out programs for family and community health improvement.

3. To interpret the services of health organizations and agencies to rural people and the needs of rural people to health organizations and agencies, so that general health programs may be effectively adapted to meet rural needs and special health programs developed to meet special rural conditions.

4. To assist rural people to understand the interdependence of local, State, national, and international health problems; on the basis of this knowledge to assist them in developing public health policy--local, State, national, and international--that will bring more and more opportunity for all people to obtain the goal of "complete physical, mental, and social well-being, not merely the absence of disease or infirmity."

The health educator's working environment

From the discussion of their job, the health educators turned to a discussion of the environment in which this job is to be done. They had come into the new extension health program from varied backgrounds of education and experience in nutrition, nursing, sociology, public health, psychology, home economics, hospital administration, social work, and agricultural economics. Some found that little preparation had been made for their coming. Sometimes they felt very lonely at first. They observed what was going on around them and fitted into programs already operating as it seemed possible for them to make a contribution.

In contrast, other extension health educators have found that the State staff has done a great deal of spadework before they arrived on the scene. Staff members have looked into the health problems confronting rural people. They have talked about the ways people can be assisted by the existing State staff and about the gaps that may be left if there is no specialist whose major responsibility is to help rural people find ways out of their health problems. These discussions have involved not only the Extension Service but also the economics and sociology department, animal husbandry, and other groups.

After preliminary discussion, sometimes the State staff has set up a committee. This committee has met with representatives of other groups in the State who share an interest in rural people's health problems. By a gradual process of cooperative thinking within the State, assisted by the specialist in rural health education from the Federal Extension Service, a policy statement has been drawn up clarifying for Extension and the entire college the new program to be developed by Extension in health education so as to serve the health needs of rural people more effectively. Within this framework, the job of a State extension specialist in rural health has been broadly defined. Arrangements have been made for the job to be one that will cut across the board in Extension--not one confined within a single operating unit. The job has also been defined as one involving close cooperation with other organizations concerned with health, such as the State department of health, the State department of education, the general farm organizations, and other groups.

The broad terms in which the policy, the program, and the job are defined leaves room for adaptation to needs as they are discovered. The place to which the specialist is assigned within Extension leaves flexibility in carrying out his functions within the general extension framework.

After orientation to Extension and the State, it then becomes easier for a new health educator to develop a family and community approach to the subject of health, supported by the whole extension staff and by other groups in the State with resources available to assist in the total job of rural health improvement.

At present extension specialists in health education are responsible to various State leaders or to the director. Some in the group felt that perhaps the new health program--in some areas still considered at least in part controversial--justifies having the specialist directly responsible to the director. They agreed, however, that for every specialist to be responsible to the director would not be good administration. Furthermore, as several pointed out, the responsibilities of the director are so heavy that he may not have time to give the new specialist the assistance he needs in a pioneering program. It was suggested that a new health educator might be responsible, at least for awhile, to the extension committee that has done the advance preparation for his coming.

However he may be assigned and to whatever person or group he may be responsible, all agreed that the way of the extension health educator should be clear to work with both men and women--to use the family approach that has been used successfully in other rural family and community living programs. As a Missouri worker pointed out, years of work through home economics clubs in Missouri produced relatively little in rural home improvements. Until a balanced-farming program was started, with the family approach as the key, a program for rural home improvement did not get far. The mother's understanding of why a balanced-farming program was important--that if such a program were put into effect, it would underwrite the family values--needed to be developed and sustained in order to have an effective program. The father's attitudes were also important; unless the father shared in the program himself, the mother might be pulling with no one coming along.

As with rural home improvement and balanced farming, health is not the concern of women alone. This was the conclusion of the group. The husband foots the bills for family health services. He is concerned with the taxes for a county health unit. The answer to a community health problem must be worked out in terms of the way society is put together. The orientation to the problem needs to be in terms of the basic community organization—the family.

First steps within Extension

In the past Extension has done many things in the general field of health. All in the group were well aware of that fact. The new effort in extension health education is directed at putting all of extension's health work into a different frame of reference so that Extension will no longer work on isolated health activities but will work on them in relation to an over-all extension health program. Going beyond that point, efforts will be directed toward putting this total extension health program into an integrated over-all extension educational program focused on the family, the farm, and the community.

In the new frame of reference, a nutrition program solely for nutrition's sake has no place. Instead the objective is better nutrition for better health, and better health for the sake of the better individual, family, and community living to which good health contributes.

The long-term goal of extension health education is to discover the how of helping people(1) to discover what they have and how best to use their existing health resources, (2) to determine their needs, (3) to develop programs in terms of those needs, and (4) to work out methods of sustaining their programs. Working toward such goals, the group recognized, might mean that the specialist in rural health education would spend a great deal of time—not on health specifically—but on community organization and planning. His work might be chiefly behind the scenes. And it might well mean that his efforts would be confined within five counties in a year instead of being spread over 75 counties.

The first contribution that a health specialist might make is to counsel with the extension director and others in the State office who make policy decisions and get an early acceptance of the idea that health will be given an important place in State extension program planning. In the counties varying degrees of emphasis will be placed on program planning. The specialist's success in getting health considered in county program planning will depend on the acceptance by State leaders of a State policy decision on this point.

If health is tied to the total agricultural planning program, it can be kept integrated with the extension program. Unless a health program implemented through health councils or other community organizations for health becomes a substantial, integral part of over-all extension planning, Extension's participation in these health organizations, and even the organizations themselves, may be only propped-up, short-lived affairs. To have stability and permanence, local activities and organizations must grow out of what is already in the community if anything is there that can be built upon, strengthened, and made to do the job.

Pilot county (See committee report, page 28)

With their current work in mind, some of the health educators considered the decision to work in a few counties or even in a single county a difficult one to make. Many programs are State-wide. The extension specialist sometimes becomes rather deeply involved with State rural health committees or with special committees concerned with different aspects of the rural health problem. Moreover, sometimes the method of assigning a specialist within Extension or within a State limits his opportunity to make decisions in regard to where and how he might work most effectively.

The question was raised whether a health specialist should become so involved in State-wide activities that he has no time for an intensive job in a few counties--whether he can afford not to go out into a few counties and do an intensive job in order to demonstrate what an Extension health program can be and what an Extension health specialist's job is based upon. The point was emphasized that result demonstrations have long been an extremely useful method of extension education.

The group decided that careful selection and development of a pilot county operation, backed by general understanding of the whole State situation, was essential if they were to really understand what processes and techniques would work in an extension health program. They might work on broad programs for 15 or 20 years without understanding one situation completely. If they could fully understand one situation, they might better analyze situations elsewhere. Even though it might not be possible to begin work in a pilot county immediately, work could be started toward the development of a pilot county.

A pilot county was defined as an exploratory operation--a proving ground for an activity. It implies a county in which the health educator and others can learn. A demonstration county would be the next step. The pilot county might become a demonstration in part of what not to do as well as of what to do. But it would be important that the final outcome of a pilot county program should be successful. Failures might be made within it. The total experiment should be a success.

The pilot county might be a point around which to organize an extension health committee or a State rural health committee if none already existed. It could also be a point to focus on in discovering the resources of the college. In addition, the pilot county would be a proving ground to demonstrate how a health program can become an integral part of an over-all comprehensive plan for the county. At no time, however, should it be publicly or privately said in the county that this is something they are doing for the health educator or for the college. Locally it should never be thought of as an experimental situation.

The ultimate goal of work in a pilot county--as of all extension health work--would be democratic planning for health--the development of widespread, well-informed opinion leading to the establishment of health habits, practices, services, facilities, and laws essential to build sound individual and community health.

The specialists believed that extreme care should be used in selecting a pilot county. In some cases, instead of a county it might be a community whose boundaries encompassed only a small part of a county. In other cases it might be an area that went beyond county boundaries.

Its typicality would be important. Unless the pilot county situation was typical of the situation in many other counties, much of the value of the pilot county as an area in which to learn and as a demonstration area might be lost.

Other important factors to consider in selecting a pilot county, the health specialists decided would include the degree of cooperation among different agencies and workers in the county, whether county extension workers have the time and interest required for an effective program, and whether they have the prestige that would enable them to interpret the health program effectively to extension workers in other counties and to administrative people. The distance the health educator must travel to reach the county must also be considered. The requirement that a county not have a health council or other type of community health organization might be an additional basis for selection.

A health specialist's first step in the development of a pilot county program probably would be to talk over the idea with people he could depend upon for support. Once he is assured of the understanding and support of a number of others on the extension and college staffs, he need not fear getting placed in a "veto" situation.

In addition, at the State level it is valuable to have the understanding and support of the health department, medical society, dental society, State department of education, and other groups concerned with a rural health program. Similar understanding and support need to be solicited at the local level.

Within a county the idea needs first to be well understood and accepted by county extension workers. Then a move can be made to the extension program planning committee, the balanced-farming committee, or other planning group in the county. If there is a county health council, the matter should be thoroughly discussed with them and their sponsorship should be solicited. Whether a previously organized committee or council or a newly organized one becomes the sponsoring body for a county health program, sponsorship should be by a representative group.

The sponsoring body should include representatives of all groups in the area--not just rural people. In Ohio and other States, it was pointed out, county health organizations are getting away from the idea of a rural set-up. Councils are changing their names from "county rural health council" to "county health council." Representatives in the sponsoring organization should be selected on the basis of who is most interested or who can make the greatest contribution - the "natural" leaders in the health field - rather than being confined to officials of organizations, all of whom in any case may be from the county seat rather than being representative of the whole county.

The size of the committee or council is likely to vary in different places and in different situations. Five or six persons might form the sponsoring body in some counties. In others the sponsoring group might include 20 or more persons. As one person in the discussion group pointed out, however, any group over 16 becomes rather hard to work with--a way of saying that democracy becomes more difficult as society becomes more complex. While the sponsoring body may be broadly representative, including a rather large membership the actual working group - a kind of executive body - might consist of only a handful of representatives elected from the total sponsoring group.

The sponsoring body might go through a process rather similar to that undertaken by the State extension committee in preparing for a specialist in health education. They might discuss what resources are available, what research has been done, and just where they are now. Then they might list what they think are problems in the county, assign priorities, think through what other agencies and organizations outside as well as within the county might do, and what resources are available to work with them in reaching a solution to existing problems. Their first step of action might be to encourage a survey to point up what they think their problems are and to serve as a base line for their future program.

The time required to carry out a pilot county project might be expected to vary in different areas. The process cannot be hurried. Particular organizations and groups within a county must find ways and means of working with a county health program in terms of the way they normally operate.

The danger of focusing on too small a purpose must be avoided. One person may have a good idea for a safety program, for example. He must be willing to place his idea on the table along with others. A very persuasive leader can become a difficult person to handle. Unless he develops a broader vision, a pilot county program may become a safety program or a sanitation program with no one quite aware of what safety or sanitation fits into. A short-range program leading to an early success may be used to initiate a long-range program and to get a local health organization off to a good start. All short-range programs, however, should be in line with and should be recognized as part of a larger objective.

One job of a county group to start might be to inventory all existing organized groups in the county. As one extension worker observed, "We could change the life of a county if we had every organized group doing one little thing."

Though the practice in different States up to the present has varied, there was general agreement among the health workers that there should be a place where the lay group might feel free to express itself. Many projects have been started with nothing behind them but professional people and a few lay people in the background who really knew little of what it was all about. The health specialist might meet first with the county agent; then with other interested people who might or might not be on any formal committee. Then this group could make a decision in regard to calling in other agencies as they were needed.

Clinton County, Ohio, survey (see page 28)

The learning process has the greatest effect on people's attitudes when they themselves acquire knowledge by an emotional experience within a group rather than by listening intellectually to someone saying something. A county survey can be an effective means of learning and at the same time developing changed attitudes if it starts with the maximum involvement of people and agencies concerned with finding out just what is the situation in a particular county.

The process of developing and making a survey in Clinton County, Ohio, was outlined. Local people themselves made the survey, sponsored by their county health council. Every agency and organization in the county can become a member and have a representative on the council. In addition, any individual interested in health is eligible for membership. Because such a large group would be unwieldy, a small executive or planning group has been chosen from the entire council membership. There is complete acceptance by every member of the council of every person in the smaller group. The general council customarily meets infrequently. The executive committee may meet every month or on call.

First the executive group in Clinton County discussed a survey. The Extension representative was there but stayed in the background. Clinton County already had an accumulation of facts about the county available. It was 2 years before the council decided to make a survey. A lot of talking was done first. The council did not want to conflict with other surveys in a highly oversurveyed county.

Then the council went into the purpose of this survey--a question they answered. Finally they built a questionnaire. Each agency and group was asked what questions they thought should be asked. The bale of questions that came in was sifted down to a list not too difficult to answer but which would give people some of the facts they wanted. These questions were brought before the whole council. If there was any question on an item, it was discussed and interpreted.

Instead of getting someone from the State college, the council decided to handle the actual survey-making itself. The trustees of each township have a representative on the general council. Leaders selected on the basis of their interest were listed from each township in the county. For the whole county, 454 enumerators were finally chosen. Someone from the council talked to each of the persons chosen for a particular area. There was always publicity beforehand in the local newspaper.

Before the survey was started in each township, sometimes two or three meetings were held at convenient locations for briefing the enumerators. No identification was written on any of the questionnaires except for the name of the township. Two weeks were scheduled for making the survey. No enumerator was assigned more than 10 families to visit. Completed questionnaires were brought into the county extension office.

Then the State health department was asked to help work up a code and the council appointed six persons, including school teachers and members of the county medical society auxiliary, to code the questionnaires. After that the health department was asked to analyze the results. The medical society was also asked to make an analysis. Finally the council made its own analysis--a way to keep people interested as well as to get statistical facts about the county's health situation and the attitudes of its people.

Of the nearly 20,000 people assigned to be surveyed, the survey covered nearly 18,000 in 5,400 families. The council found that State records did not always coincide with the facts revealed by the survey. From "rooting around" they discovered a number of things they did not like.

The survey also provided one method of developing leadership. Local surveyors could compare their results with those of other enumerators in the same general area. If a surveyor did not do a good job, he could find that out by comparing his results with those of others. Each representative from the council organized the work in his own area--another chance to develop leadership as well as to find new leaders in an area.

Surveys and survey methods

After the discussion of the Ohio county health council and its survey, the group took up general objectives of surveys and desirable survey methods. It was agreed that the Ohio survey actually had two major objectives: the first a specific research objective and the second to develop a consciousness on the part of the people--all the people--of existing health conditions.

The importance of careful survey planning was emphasized. The findings must be valid. The answers to questions must be the facts people want. With each question in a questionnaire, a group should ask, "Does this question contribute anything in terms of survey objectives? Would the answer give us facts we need? Would it help develop community consciousness of problems?"

Guidance is needed in developing survey forms and procedures. Using the help of an outside agency, however, does not necessarily mean that that agency will take over the job.

Before a survey is made, a group should know what has already been done in the field. It should also look into possibilities of obtaining needed information by getting additional questions included in other current surveys. It may decide to use facts already available instead of making its own study. If the experience and things that are known can be mobilized and brought into focus on a particular problem, there is no point in making another survey.

If a survey is decided upon, however, the population to be surveyed needs to be considered--where they live, their age, and other characteristics. A decision must be made whether the survey should cover the universe or whether the findings from a sample may be just as valid or even better. Even though a sample may be less work and may develop as valid information, the degree to which development of over-all consciousness of health problems is an important survey objective must also be considered. Decisions in such matters can be made on a more valid basis if outside resources such as those of the State college and the Bureau of Agricultural Economics are fully used.

The desirability of setting up a standard to aim at along with the questions on a survey form was discussed. An undirected survey with no standards set up is unlikely to be worth while. On the other hand, care should be taken to avoid influencing the answers by statements in regard to standards.

An inventory guide and questionnaire form that could be used by a home demonstration club or other form of organization was briefly considered. Further discussion was concerned with the areas of information that might be covered by a survey, the way in which questions might be asked to stimulate more effective use of services as well as to motivate groups to work toward establishment of more adequate services, and the need for pre-testing a questionnaire form.

It was the consensus of the group that questions so obvious that they call for only a yes or no answer may be quite ineffective and may be resented. Questions that stimulate people's thinking are likely to produce better results.

Whatever survey forms and methods may be worked out, the over-all objective is to help people discover what they themselves need and want. This was the group's general conclusion. They also felt it is more effective for local people themselves to reach the decision that they need a local public health unit than to start by saying that we want to get public health units laid down all over the Nation. As one specialist said, even if a health department existed in every county, it wouldn't necessarily be used effectively.

At all stages of study the people who are concerned should be kept informed. Communication, involvement, and action are the three steps to be emphasized in planning and carrying out a survey. The public should be prepared beforehand for a survey. This may take a rather long preliminary process of education as well as publicity immediately before and during a survey. The results should also be reported back to the public.

Publicity at all stages should center on what people are doing rather than what they plan to do. The leaders of organizations in the county should be encouraged to handle the presentation of facts at meetings of their own organizations.

Evaluation

Problems of reporting and of job evaluation came up from time to time from the first day of the conference. Extension has relied heavily upon numerical measurement for all its programs. The question was raised--What can the health specialist do? Will he measure the progress people have made in health improvement by the number of babies immunized, the number of persons who have had a chest X-ray, or the number attending meetings? Or should he emphasize the type of activity undertaken and the type of program initiated?

Again the possibility of using the pilot county was discussed. Since evaluation can only be in terms of stated objectives, the purposes of a pilot county program must be clearly stated. The different approaches or methods used can also be stated, and the effectiveness of each can be outlined in terms of the results achieved.

The work in tuberculosis in an Indiana county was outlined (see page 30), along with the possibilities of evaluating that work in terms of the specific objectives and in terms of methods used and their effectiveness. The county had a rate of 64 deaths from tuberculosis for each 1,000 residents--about twice as high as the rate in adjoining counties and the State as a whole. No agency had ever been able to arouse the people. Extension helped the community organize and carryon an intensive educational campaign. First a small group of interested people came together. Then a committee with a chairman was set up including three people from each political subdivision of the county. That involved getting out and walking up and down dirt roads to talk to people. Then groups of leaders were brought in to learn about the tuberculosis situation in the county. Finally a township meeting was held.

The same process was carried on all over the county. Eventually 500 people were working on the project. Then the mobile X-ray unit was requested. When it came in, nearly 80 percent of the adult population was X-rayed. Ten percent of the films were positive. At that point local people found there were no facilities for follow-up and no public health nurse in the county. So local people got facilities set up for follow-up and for getting people under treatment. The difference in the people after this experience was the most important outcome of the project. People had worked together toward a common objective and many people had been involved.

The attempt of the group to evaluate this project from the point of view of its objectives brought out the fact that some factors were unknown and that some of the project's possibilities perhaps had not been fully realized (see page 30).

The importance of a regular scheme for evaluation, particularly in a pioneering job, was pointed out. How far a person has gone is less important than whether or not he is working in the right direction. In developing a pilot county project, for example, a worker needs to go as fast as he can and still keep the understanding of others concerned. In some States it would be possible to move to specific operation in a pilot county within 3 months. In other places it might take a year. A health specialist who is so involved at present that he has no free time for a pilot county project has a problem to free himself so he can start this process.

In appraising a pilot county project, something more than generalizations is necessary. A worker needs to know the specific objectives, where the project started, where it ended up, what methods were used and how well they worked, the relationships developed and how effective they were, local attitudes before and after the program started, and other aspects of a local health program. With these definitely outlined, he has a basis for evaluating the county program and his own job.

Working relationships

For every extension specialist, the question arises of his relationships to other extension workers--direct or indirect--and to local people--direct or indirect. Sometimes a specialist may become a jack-of-all-trades, actually spending much of his time during a year substituting for county agents or home demonstration agents in his own field of work.

The pilot county project can be carried on with the objective of getting it established in a way that makes it possible for county workers to carry on without the specialist. Because health is a new field, it may be desirable for the specialist to work fairly directly with local people for a while until he learns more about the State and local situation and more about the problems of the county agent. In this way he can get his feet on the ground and can gradually assume the role of working directly with the staff and only indirectly with the people.

Some agent training, however, may be done from the beginning. Caution needs to be taken in working with the people that the agent does not develop the idea that the specialist is the person who works directly with the people in the health field. If the specialist goes in by himself and leaves, there is no follow-through. In the long run, he may do better to spend an hour with the local Extension staff than to spend 4 hours alone doing a thorough exploratory job with local people.

The only excuse for having a specialist at the State office is to help the rest of the staff think their way through on programs and give over-all leadership to see that these programs are going in the right direction and are sound. Therefore, at the county level the eventual objective and the responsibility of the health specialist are to get county workers so completely sophisticated in the health field that they can carry on without him. Local people must assume responsibility in local problems and local organization.

The discussion brought out the fact that each person has his own field but he can't pull the shade down entirely on the world outside. On the other hand, a health specialist must put on blinders in some cases or he will find himself doing many little jobs and failing to do the big job for which he is responsible.

For a health specialist, putting on blinders may involve adopting somewhat different relationships from those he now has to other individuals and groups in his State. In some States, for example, the specialist now serves as secretary of the State health planning committee and may also serve as secretary of its subcommittees. Other States have started with this same arrangement but finally have had a divorce with mutual understanding. A member of the college staff may be secretary and the health specialist may still report to the committee. But the health specialist is relieved of the burden of work for the committee.

Similarly with 4-H, in many States the specialist in health education is relied upon for planning the health part of the 4-H program. In other States the specialist works with the person in charge of 4-H health in planning the over-all program, the health aspects of leader training, and 4-H health materials. But the main responsibility rests with a person who is charged with responsibility for the 4-H program. The health specialist acts in an advisory capacity.

The group concluded that the specialist in health education has an advisory responsibility but should have no administrative responsibility in regard to the health programs of 4-H clubs, home demonstration clubs, agricultural agents' groups, and other Extension organizations. In addition the specialist may act in an advisory capacity to the home demonstration council, the agricultural engineers, or to other groups interested in special aspects of health or special health programs--taking care that the major focus does not become fixed on the subsidiary program.

In his advisory capacity the health specialist can help the whole of Extension begin to take greater responsibility in the field of health. He can help get health planning an accepted part of Extension's work in a county. As with other Extension specialists, he has a responsibility to see the total situation and to see how his specialty makes its contribution. Specialists have sometimes forgotten that it is the total person and the total community that are important. A specialist can make a contribution by helping to find out how his specialty makes a contribution to the total man and the total community.

Outside the Extension service, some of the people in public health and related agencies to whom the Extension specialist in health education would naturally turn are not in a position to reach rural people as effectively nor do they always have an appreciation of rural people and their needs. The health specialist makes no attempt to usurp or duplicate the jobs of these people. Instead he collaborates with them in developing and preparing material to meet rural needs and works with them in other ways, interpreting the needs of rural people to them and interpreting their resources and services to rural people. Playing the part of "middleman" between official and voluntary agencies and rural people is among the extension specialist's most important functions.

Methods and techniques

With the pressure to arrive at satisfactory solutions to some major problems, the discussion of methods and techniques for carrying out Extension's health program came up only briefly near the end of the conference. The following were among the methods and techniques suggested for carrying out the functions of an extension health worker:

1. Pilot county project.
2. Demonstration in community organization to solve a specific problem.
3. Leader training.
   a. Agents.
   b. Others.

4. Preparation of educational material focused on the process by which people meet needs--bulletins, posters, radio programs, visual aids, study guides, news letters, and so forth.
5. Workshops, institutes, conferences, discussion groups.
6. Open meetings.
7. Conducted tours.
8. Community self-surveys made by and for local citizens.
9. Health committees or councils.
10. Community self-evaluation.

The need for an educational process to precede an action program was emphasized. The danger involved in overlooking this need was pointed up by a story about the screening of homes in an Arkansas community. Flyborne diseases were especially common in the area. The health department and a few businessmen decided to screen all homes, free of charge. When a check was made the following year, the screens had been torn down and the frames used for kindling.

As part of the educational process, the specialist can interpret standards and give guidance in the development of thinking in determining needs and their priorities--help people recognize problems and see how the problems they recognize fit into a still larger world. Settling for what people first say are their needs may sometimes make it difficult or impossible to stimulate further thinking and better planning. Accepting the first disease they want to work on, for example, may lead to a specialist's becoming involved in scattered and more or less unrelated activities. People's ideas of what they need will change as their thinking evolves. Education must be along the lines of causes--not symptoms. And it must be education that will develop people--that will modify or entirely change their attitudes as they develop greater understanding of what good health means, what is required to maintain it, and what it can mean to themselves and their communities to maintain high health standards.

One member of the group pointed out that a problem is unlikely to be adequately defined either by the people working alone or by the specialist working alone. Two bodies of knowledge must be brought together, folk knowledge and scientific knowledge. The specialist's responsibility is to bring scientific knowledge to the people so that when they work toward something, it will be something with acceptable standards.

Review of health educator's role

Toward the end of the conference the group reiterated the statement that a primary concern of the extension health educator is in helping to get established the basic services required for modern medicine to be made available to rural people with the objective of preventing disease and promoting health for the sake of the better family and community living thereby made possible. The extension program to which the health educator gives leadership is focused chiefly on assisting with the process by which communities can organize to study their needs and to work out ways of meeting them. His tools include an

appreciation of the factors involved in physical, mental, and social well-being; knowledge of ways to aid people in doing simple research; knowledge of group discussion methods to bring out people's decisions by a democratic process; the ability to work with many different kinds of groups with different interests and then bring them together; and the ability to prepare attractive information materials that will help groups solve their problems.

In one respect, a health specialist plays the role of evangelist in developing a new program. He also has an interpretative role. In this he acts as a kind of middleman--interpreting rural needs to public health agencies, the Extension staff, and other groups, and interpreting to rural people the services of these groups. Finally he has a catalytic role in which he helps to bring together all the persons and agencies that can play a part in helping a community to help itself to better health. In each of his roles the group believed that the extension health educator must be constantly self-analytical, critically analyzing where he is going and the methods he is using to get there.

Over-all view 1/

The conference closed with the thought that as our society becomes more highly organized, each individual has greater group responsibilities. The preservation of individual freedoms with the development of greater collective security is an issue of the present day. Recognition of individual and group responsibility; clear, informed thinking; and sound planning leading to constructive action are essential for a health program that will be effective in meeting the needs of rural people as well as the needs of all others--community-wide--whether the community considered be the neighborhood, county, Nation, or world.

1/ This manuscript has been reviewed informally by Dr. Carley M. Derryberry, Chief of the Division of Public Health Education, U. S. Public Health Service; Miss Helen Johnston, Health Economist, U. S. Public Health Service; and Dr. Douglas Ensminger, Head, Division of Extension Education and Training, Technical Collaboration Bureau, U. S. Department of Agriculture.

# APPENDIX

## Extension Education on the Hospital Construction Program and Heart Diseases

Immediately after the American Medical Association Rural Health Conference held in Kansas City, February 3 and 4, 1950, the extension health educators met for 5 days from February 5 to 9. It had been possible to arrange for Dr. Louis Reed, of the Division of Medical and Hospital Resources, U. S. Public Health Service, and Mrs. Vivian MacFawn, of the American Heart Association, to stay over for one day to meet with the Extension health workers. The first day, Sunday, February 5, therefore, was devoted to a consideration of the hospital construction program and that on heart diseases. Since this was the only day devoted to subject matter, it seemed best to report separately. The following topics were considered: Progress in the hospital construction program, what rural people need to know about the hospital program, the role of the Extension Service in the hospital program, and the educational program on heart diseases.

### Progress in the hospital construction program

All the States are now participating in the hospital construction program. All have made a survey of their hospital needs and submitted plans for construction of additional facilities. All have given priority ratings to communities according to needs. All States must submit a revised plan annually to the Hospital Facilities Division of the USPHS. Some States have made two or three revisions to date. Constant changes are made in redetermining hospital areas, based on better knowledge of all the elements to be considered.

At the end of December 1949, 1,091 projects for hospital and health center construction had been approved. The total construction costs amounted to nearly $700,000,000, with the Federal share a little over $200,000,000. The distribution of projects according to type has been as follows:

| | Percent |
|---|---|
| General hospitals | 78.2 |
| Mental hospitals | 4.6 |
| Tuberculosis hospitals | 2.6 |
| Chronic disease hospitals | 0.8 |
| Public health centers | 13.8 |

Federal funds were going to these projects in almost the same proportions. Of all Federal funds 85 percent went to general hospital projects; 2 percent to health centers; and between 3 and 4 percent each to mental and tuberculosis hospitals.

One-half of the general hospital projects are for completely new facilities. However, more of the money is being spent for additions to existing hospitals than for building new ones. This is especially true of mental and tuberculosis hospitals.

Of the new general hospitals being built, 68 percent are for hospitals of fewer than 50 beds and only 11 percent for hospitals that will have 100 beds or more.

For the most part, the new general hospital projects will be located in small towns; 71 percent are in communities of less than 5,000 population. Less than 5 percent are in cities with a population of 25,000 or more.

Although two-thirds of the new general hospital projects are for facilities with fewer than 50 beds, only one-third of the Federal funds is going into the construction of these smaller facilities. Slightly more than one-third of the Federal money is for construction of new hospitals having 100 beds or more. For those projects that involve additions or alterations to existing facilities, three-fourths of the Federal funds are going to hospitals with 100 or more beds.

The program as a whole is working very well in helping communities of average and below-average income to build hospitals. It has not been possible to help to the same extent the very poorest areas. Analysis of the factors which have prevented certain high priority areas from building hospitals has shown that lack of money, lack of interest, and perhaps lack of total economic resources have been major ones.

What rural people need to know about the hospital program

There was general agreement that the hospital construction program was outstandingly successful. It has brought hope to many rural communities that something can be done to improve their health and medical services. Many rural people begin to see the place of the hospital in a total health program and the importance of modern health care being made available through strengthening relations between the small and large hospital centers. It was felt that in the poorest rural areas much educational work needs to be done.

In spite of the excellent progress made by the hospital construction program, the Extension health educators felt that much more of an education program was needed among all rural people along the following lines:

1. Clarification and interpretation of what a coordinated hospital system is.
2. A clear understanding of the functions and services rendered by such facilities within a coordinated hospital system, as:
   a. The general hospital.
   b. A health center.
   c. Community clinic.
   d. Emergency centers.
   e. Ambulance service.
3. More understanding and appreciation of the problems invovled in maintaining and operating a hospital or health center, with special reference to:
   a. Financing.
      1. Total sources of funds for maintaining and operating a facility.
      2. Public financial support and how raised.
      3. The financial contributions by individual families through either prepayment schemes or some other method which would help to maintain the facility and provide some health protection to the family.
   b. Getting and keeping doctors, nurses, technicians, and all other health personnel.
   c. Building and keeping up standards for good hospital and medical care.
   d. Community responsibility for building and operating a hospital and maintaining a high standard of health and medical services.

The role of the Extension Service in the hospital program

The extension health educators considered that because this program had such special significance for raising health standards in rural areas the Extension Service should have a continuing contribution to make toward its success. They decided that the Extension Service should continue a cooperative educational program with State health departments and the U. S. Public Health Service in the following ways:

1. Provide information on the State hospital plan, the Federal law, and what a coordinated hospital system could mean to rural areas.
2. Facilitate understanding between official agencies and community groups as to the function, services, and desirable standards of different types of facilities.
3. Make available to State agencies and local communities socioeconomic data obtainable from the research departments of colleges of agriculture and other sources that would help in the development of effective local and State planning.
4. Bring to community groups information available from State health departments, the U. S. Public Health Service, and other health agencies concerning the problems involved in maintaining and operating hospitals and other health facilities. Such information should put special emphasis on:
   a. Problems of financing - family and community.
   b. Responsibility in regard to having adequate supply of all health personnel.
   c. Problems of maintaining desirable health standards for the facility.
   d. The role played by many groups and individuals in the successful construction and maintenance of the health facility.

Educational program on heart diseases

In June 1948 Congress passed the National Heart Act. This created a National Heart Institute within the U. S. Public Health Service for the purpose of developing and supporting research and treatment of diseases of the heart and circulation. At this same time, the American Heart Association, which had been a scientific organization, changed its structure to become a voluntary health association with a lay membership. Its purpose is to supplement public efforts with respect to (a) research; (b) community services; and (c) education.

Since December 1949 several meetings have been held in the U. S. Department of Agriculture of representatives of the U. S. Public Health Service and Children's Bureau, concerned with this program, the American Heart Association, and the Federal Extension Service. The purpose of these meetings has been to determine how the Extension Service can assist in the educational work relating to this program. Since the heart and circulation are affected by many diseases, this program puts its major emphasis on the preservation of health in which care of the heart and circulatory system are an important part.

One project that has been developed by the A.H.A. that is helpful to women who have been hospitalized and must return to their regular household duties is "the cardiac kitchen" which takes off any undue strain from the homemaker.

A letter from Director Wilson to State extension directors describing this cooperative educational program has included materials from all the agencies concerned. The plan is to follow this up with further material suitable for

4-H and home demonstration clubs. A good description of the program may be found in "The Heart of America" prepared by the A.H.A. There is also a pamphlet prepared by the Public Affairs Committee entitled "Know your Heart," which gives a good description of all the elements essential to effective community planning for care of heart diseases.

It was felt that this was one example of the way in which State extension services and voluntary and public organizations concerned with special programs might make their services more readily available to all rural people. On the other hand, it was pointed out that it was important that all special programs be given their proper place in relation to an over-all Extension health program focused on family and community health needs.

## The Pilot County (Committee Report)

The pilot county plan aims to test extension methods, program planning, and program content. It should serve as a proving ground to test the validity of methods and techniques. One should expect to make mistakes and to use the pilot county to remove flaws in the basic planning of the over-all health program.

The pilot county should serve (1) to mobilize effectively the total resources of the county toward better health, (2) to effect the total mobilization and involvement of people and organizations, and (3) to develop a total county health program -- all steps to bring action to bear on carefully defined health problems in the county concerned. The pilot county may eventually serve as a demonstration to other areas interested in over-all health planning.

A. Reasons for developing pilot county project.

1. Provides an area within which to experiment and demonstrate ways whereby health planning can be effectively integrated into over-all extension process.

2. Provides in-service training opportunities for extension health specialist, administrative staff, and others.

3. Provides a testing ground for extension methods as well as for developing new methods.

4. Provides opportunity to test cooperative planning for solving a specific health need in a county.

5. Helps establish the role of the health specialist in the State and county.

6. Provides a specific framework within which to develop effective working relations within the college and between State and local agencies.

7. Provides an opportunity to evaluate the continuing effects of extension work through concentrated effort in one county where definit objectives and methods can be set up and results measured.

B. Steps in selection of pilot county and initiation of pilot county project.

1. Obtain administrative endorsement and active cooperation.

a. Discuss pilot county plan fully with State extension health committee; if there is none, request director to appoint a State extension health committee for this project.

(1) Committee might include the director or assistant director, members of supervisory staff, specialists, representatives of county and home agents, and perhaps others.

2. Role of State committee.

a. Determine factual basis for selecting pilot county (sociological, economic, distance from State office, and so on).

b. Consult with other State agencies in regard to selection of county.

c. Consider county personnel as to prestige, interest, and cooperativeness.

d. Select prospective counties.

e. Present plan to county personnel for discussion and approval at district conferences or other meetings of county workers.

3. County planning procedure.

a. Develop thorough understanding of plan through discussion between county extension personnel and district supervisors, health specialist, or other members of State health committee.

b. Discuss the proposed project with county planning committee.

c. Get the cooperation of sponsoring group within county.

(1) Group should be representative of all segments of county population. If there is county health council or committee, expand membership if necessary to make it representative. If there is no such group in county, get one set up.

d. Role of sponsoring group.

(1) Develop written plan of procedure including: (a) definition and discussion of health problems; (b) inventory of existing resources, facilities, agencies (official and voluntary), and other interested groups; (c) assignment of priority to problems.

C. The action phase.

1. Develop and conduct surveys.

a. Make a formal survey of individual and community health needs -- attitudes, practices, facilities, and so forth.

2. Have surveys tabulated by community leaders making the survey.

3. Health specialist, county personnel and other resource persons summarize and analyze survey materials.

4. Hold meeting of sponsoring group to consider the analysis and plan for open meeting.

D. Develop health program.

1. Discuss findings of surveys at open meeting.

2. Initiate educational program through newspaper, radio, group meetings, and the like.

3. Distribute survey findings to all groups represented; request these groups to discuss findings at their next meeting (within next month) and report their recommendations and problem priorities (this should be well planned, with special forms for reporting, including self-addressed

envelope). Request report be made to county chairman of planning committee within given time.

4. Hold meeting of extension health committee for review of recommendations and priorities assigned by different groups.

5. Present progress report to State health committee.

6. Select major problems to include in current program based on immediate and long-term needs.

E. Develop an action program.

Outline of Survey Objectives 1/

1. Establish over-all purposes of survey.
   a. Education and group involvement.
   b. Careful collection of valid facts (research).

2. Determining survey objectives by defining those areas for which information is needed.
   a. Determining existing health conditions involving --
      (1) Maternal and child hygiene.
      (2) Environmental sanitation (drinking water, sewage disposal).
      (3) Chronic disease incidence.
      (4) Status of vaccination and immunization.

   b. Determining significant differences between rural and urban population areas as to conditions.

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Byproduct: Developing consciousness on the part of all the people of existing health conditions.

Evaluation in Terms of Objectives in Indiana County Tuberculosis Program

Objectives:

1. Reduce incidence of tuberculosis.
2. Create immediate interest.
3. Stimulate action to meet need.

Evaluation in terms of objectives:

1. Eighty percent of adult population had chests X-rayed. Ten percent or so of the X-rays were positive.

2. Got nurse in county to work with families and get those needing treatment cared for.

3. Brought pressure on local doctors to do better job in relation to tuberculosis.

4. Interest was aroused leading to other action.

1/ Based on Clinton County, Ohio.

Unknown factors:

1. How many were cared for in sanitariums?
2. Have local people related incidence of tuberculosis to nutrition and other causes?
3. What measures have been taken to remove causes?
4. Was there carry-over knowledge and enthusiasm to do more things?

## Role of Extension Health Educator (Committee Report)

A. Major area of work.

The special focus is on helping rural people with the process by which the interest, initiative, support, and participation of all the people in the entire community may be enlisted to study the facts relative to the health and medical needs of each family in relation to the total community; to develop plans and programs to meet their needs; to mobilize all the resources within themselves and their environment -- local, State, regional, and national -- needed to carry out programs for family and community health improvement.

B. Knowledge needed based on appreciation of factors involved in physical, mental, and social well-being.

1. Sociological, economic, and psychological factors affecting health of the individual, his family, and the community.

2. Information about and understanding of desirable standards for habits, practices, laws, services, and facilities, for improving and maintaining health.

3. Social process by which individuals and communities mobilize their potentialities and strengths --
   a. To make effective use of existing knowledge of habits, practices, laws, services, and facilities, for improving and maintaining health.
   b. For developing individual and community responsibility for establishing, maintaining, and improving health habits, practices, laws, services, and facilities.
   c. For developing action programs leading toward desirable health goals.

C. Major functions.

1. Preparation of all types of subject matter in areas listed in 3a under B.

2. Getting health program initiated in the total extension program by --
   a. Organization and development of a State extension health committee or other similar administrative group.
   b. Developing in the total extension staff an appreciation of the contribution of the health specialist to the total program of Extension and the college and university.
   c. Pointing up how other specialists, extension workers, and resident staff — the total resources of the college and university — may contribute to rural health improvement.

3. Developing the health program within agricultural planning groups on State and county levels.

4. Establishing and maintaining channels of communication between all health agencies and rural people including conveying needs of rural people to the agencies.

5. Cooperating with farm and rural organizations, State health committees, medical societies, and other agencies in the development of their health program, particularly as it affects rural people.

6. Developing methods of evaluation in relation to objectives and methods.

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